Florida Department of Health, Citrus County Health Department Dental Sealant Program

Dear Parent/Guardian: Teacher name: _____

A Dental Sealant Program will be coming to your child's school. **This program is offered to all 6th graders (at no cost to parents / guardians) and helps prevent tooth decay**. A licensed dental hygienist will look at your child's teeth and decide which back teeth need to be sealed. Those teeth will be coated with a dental sealant and a fluoride treatment given. Your child will not be given any sedatives, medications, fillings, or x-rays. Sealants can protect against 85% of chewing surface cavities and are safe, painless, and simple to apply. Dental sealants and fluoride are approved and recommended by the American Dental Association, Centers for Disease Control and Prevention, and the Florida Department of Health.

PLEASE FILL OUT IN INK, SIGN, AND RETURN THIS FORM TO YOUR CHILD'S TEACHER

I give my child permission to receive a dental assessment and charting, sealants (if applicable), and a fluoride treatment.

Name of Child: _____Date of Birth:_____ ☐Male ☐Female

Address:_____City:_____Zip Code:_____

Race/Ethnicity: ☐White ☐Black/African American ☐Asian ☐Hawaiian/Pacific Islander ☐Hispanic ☐American Indian/Alaskan Native ☐Other

Select your child's insurance: ☐Medicaid ☐Private Insurance ☐None

Child's Medicaid Number: _____

Child's Parent/Guardian's Name: _____Relationship to child: _____

Telephone: Home: _____Cell: _____Work: _____

CHILD'S HEALTH HISTORY

Please check YES or NO for each of the following regarding your child's health:

	YES	NO
History of rheumatic fever? ☐ Heart murmur?☐ Asthma?☐		☐
My child needs to take antibiotics (e.g. amoxicillin) before dental care: _____	☐	☐
My child cannot take or is allergic to the following medications or materials: _____	☐	☐
My child has the following health problem(s): _____	☐	☐
My child is taking the following medication: _____	☐	☐
My child was hospitalized in the last 2 years for: _____	☐	☐
My child experienced the following unfavorable reaction from previous dental treatment: _____	☐	☐

Please add any comment or additional information: _____

_____

I certify that I have READ and UNDERSTAND the above questions and have answered them to the best of my knowledge. This dental care may include: dental assessment and charting, sealants, fluoride and oral health instructions. I understand that my child is not being provided other dental care that she/he may need. These services are not a substitute for a comprehensive dental examination. I authorize the dental providers to receive payment from any insurance or any third-party payor that covers the services provided to this patient. If you have any questions, please contact our office at 352-513-6028. 9/2019-rg

Parent / Guardian Signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____